GUARDIANSHIP INTAKE AND REFERRAL FORM

Thank you for requesting the services of this agency. We understand that not all of the information asked for on this form may be available at the time of the referral. Nevertheless, please fill out as completely as possible.

Date: _____

CLIENT INFORMATION (AIP Alleged Incapacitated Person)

Client's Name _____ Also Known As: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ Age: _____ Race: _____

Birth Place (if known): _____ Religion: _____ U.S. Citizen: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower Name of Spouse: _____

SSN: _____ - _____ - _____ Primary Language: _____ County of Residence: _____

Current Location: _____

Current/Previous Occupation _____

If facility, admission date: _____ Phone: _____

HOW DID YOU HEAR ABOUT LSF?

Category (check the appropriate one): ☐ Nursing Home/ALF ☐ Hospital ☐ State Agency

☐ Home Health ☐ Law Enforcement ☐ Court ☐ Other

Name of Agency: _____

Contact Person: _____

INFORMATION OF PERSON COMPLETING FORM

Name: _____

Relationship to Client: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Reason why guardianship is needed *(Please be specific, thorough and convincing. Attach additional sheets if necessary.)*

Examples of Client's behavior (*Attach additional sheets if necessary)*:

MEDICAL

Primary Physician: _____ Telephone: _____

Address: _____

Specialist: _____ Telephone: _____

Address: _____

Specialist: _____ Telephone: _____

Address: _____

Psychiatrist: _____ Telephone: _____

Address: _____

Diagnosis: _____

Prognosis: _____

Long Term Plan: _____

Allergies: _____

Medical History: _____

Mental Status / Level of Functioning: _____

<u>LEGAL/ESTATE PLANNING</u> Attach copies (if available)

Client's Attorney: _____ Phone Number: _____

Power of Attorney: ☐ Yes ☐ No

Name of POA: _____ Contact Number: _____

Address of POA: _____

Is there a Health Care Surrogate: ☐ Yes ☐ No ☐ Unknown

Name of HCS: _____ Contact Number for Surrogate: _____

Address of Surrogate: _____

Does client have a will: ☐ Yes ☐ No ☐ Unknown Location: _____

Is there a trust? ☐ Yes ☐ No ☐ Unknown Location: _____

Name of Trustee: _____ Contact Number: _____

Address of Trustee: _____

Advanced Directives: ☐ Yes ☐ No ☐ Unknown Location: _____

Is there a living will? ☐ Yes ☐ No ☐ Unknown Location:

_____

Are there burial plans? ☐ Yes ☐ No

With whom and Contact Number: _____

FINANCIAL

Monthly Income: SS $_____ SSI $ _____ SSDI $ _____ Pension $_____

Annuities _____ VA $_____ Veterans ID: _____

INSURANCE

Medicare No.: _____ Medicaid No.: _____ Other Insurance: _____

ASSETS / PROPERTY (Including Property, Bank Accounts/Trusts/Automobiles/Life Insurance, etc.)

Real Estate: ☐ Yes ☐ No Location: _____ Approx. Value: $ _____

Automobile: ☐ Yes ☐ No How Titled: _____ Approx. Value: $ _____

Investments: Type: _____ Approx. Value: $ _____

Bank Accounts:

Name of Bank: _____ Approx. Value: $ _____

Address: _____ Telephone: _____

Name of Bank: _____ Approx. Value: $ _____

Address: _____ Telephone: _____

DEBTS:

Mortgage: $_____ Credit Cards: $_____ Car Loans: $_____

Medical Bills: $_____ Other Debt: $_____

RESIDENCE

Permanent Address: _____

Anyone Living with Client? ☐ Yes ☐ No Name: _____

Relationship: _____ Telephone: _____

FAMILY/SIGNIFICIANT OTHERS:

Name: _____

Address: _____

Relationship: _____ Telephone: _____

Name: _____

Address: _____

Relationship: _____ Telephone: _____

Name: _____

Address: _____

Relationship: _____ Telephone: _____

Name: _____

Address: _____

Relationship: _____ Telephone: _____

COMMUNITY RESOURCES INVOLVED WITH CLIENT:

Agency: _____ Contact Person: _____

Address: _____ Telephone: _____

Agency: _____ Contact Person: _____

Address: _____ Telephone: _____

Agency: _____ Contact Person: _____

Address: _____ Telephone: _____

If for Guardianship, who will petition the Court for the Guardianship?

Name: _____ Telephone: _____

Address: _____

ADDITIONAL COMMENTS:

COMMUNITY HIGH RISK REFERRAL SCREENING FORM

AIP NAME: _____

Is the AIP (alleged incapacitated person) and APS (adult protective services) referral OR had an open APS case in the past 6 months? ☐ YES ☐ NO ☐ UNK

Has the AIP had 2 or more hospitalizations within the past year (medical or voluntary mental health/substance abuse treatment)? ☐ YES ☐ NO ☐ UNK

Has the AIP had 2 or more ER (emergency room) visits in the past 6 months? ☐ YES ☐ NO ☐ UNK

Has the AIP been Baker Acted in the past 6 months? ☐ YES ☐ NO ☐ UNK

Has the AIP had 1 or more arrest in the past 6 months? ☐ YES ☐ NO ☐ UNK

If the answer is "YES" to any of the above criteria, the AIP will be considered a **COMMUNITY HIGH RISK**

HOMELESSNESS RISK ASSESSMENT

Currently homeless? ☐ YES ☐ NO ☐ UNK

Eviction/foreclosure/shut-off notice pending? ☐ YES ☐ NO ☐ UNK

In hospital w/no safe discharge plan? ☐ YES ☐ NO ☐ UNK

Unable to manage/pay current living expenses? ☐ YES ☐ NO ☐ UNK

If the answer is "YES" to any of the above criteria, the AIP is considered a **POTENTIALLY HOMELESS INDIVIDUAL**